Assembly Bill No. 2732

Passed the Assembly August 4, 2014

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Chief Clerk of the Assembly

Passed the Senate July 3, 2014

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Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2014, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 4600, 4610.5, 4903, 4903.07, 4903.8, and 5410 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 2732, Committee on Insurance. Workers' compensation.

(1) Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment. Existing law generally provides for the reimbursement of medical providers for services rendered in connection with the treatment of a worker's injury, and requires an employer to establish a medical treatment utilization review process, in compliance with specified requirements. Existing law provides for an independent medical review process to resolve disputes over a utilization review decision for injuries occurring on or after January 1, 2013, and for any decision that is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury. Under existing law, as part of its notification to the employee regarding an initial utilization review decision that denies, modifies, or delays a treatment recommendation, an employer is required to provide the employee with a one-page form prescribed by the administrative director, and an addressed envelope, which the employee may return to the administrative director or the administrative director's designee to initiate an independent medical review. Under existing law, an employer is required to include on this form any information required by the administrative director to facilitate the completion of the independent medical review. Existing law specifies the required contents of the form.

This bill would revise the requirements applicable to utilization review procedures by changing the maximum length of the above-described form to 2 pages.

(2) Existing law authorizes the Workers' Compensation Appeals Board to determine and allow as liens against any sum to be paid as compensation, certain amounts, including, but not limited to,

reasonable medical treatment expenses, except those disputes subject to independent medical review or independent bill review.

This bill would include in those amounts that the board is authorized to allow as liens certain medical-legal expenses to which the employee is entitled under a specified provision for the purpose of proving or disproving a disputed claim.

(3) Existing law requires that a lien claimant in a workers' compensation matter is entitled to an order or award for reimbursement of a lien filing fee or lien activation fee, together with interest at the rate allowed on civil judgments, if certain conditions are satisfied.

This bill would specify that these fees are to be paid by the employer of the injured worker.

(4) Existing law requires an order or award for payment of a lien for medical or hospital treatment in a workers' compensation matter to be made for payment only to the person who was entitled to payment for the expenses for medical or hospital treatment at the time the expenses were incurred, and not to an assignee unless the person has ceased doing business in the capacity held at the time the expenses were incurred and has assigned all right, title, and interest in the remaining accounts receivable to the assignee.

This bill would authorize an assignment of that payment if the assignment was completed prior to January 1, 2013, or if it was required by a contract that became enforceable and irrevocable prior to January 1, 2013. The bill would state that this provision is declarative of existing law.

(5) Existing law authorizes an injured worker to institute proceedings for the collection of compensation, including vocational rehabilitation services, within 5 years after the date of the injury upon the ground that the original injury has caused new and further disability or that providing vocational rehabilitation services has become feasible because the employee's medical condition has improved or because of other factors not capable of determination at the time the employer's liability for vocational rehabilitation services otherwise terminated.

This bill would delete the provisions relating to vocational rehabilitation, but retain the authority of an injured worker to institute proceedings for the collection of compensation within 5 years after the date of the injury upon the ground that the original injury has caused new and further disability.

The people of the State of California do enact as follows:

SECTION 1. Section 4600 of the Labor Code is amended to read:

4600. (a) Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatuses, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer. In the case of his or her neglect or refusal reasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment.

(b) As used in this division and notwithstanding any other law, medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27.

(c) Unless the employer or the employer's insurer has established or contracted with a medical provider network as provided for in Section 4616, after 30 days from the date the injury is reported, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area. A chiropractor shall not be a treating physician after the employee has received the maximum number of chiropractic visits allowed by subdivision (c) of Section 4604.5.

(d) (1) If an employee has notified his or her employer in writing prior to the date of injury that he or she has a personal physician, the employee shall have the right to be treated by that physician from the date of injury if the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a plan, policy, or fund as described in subdivisions (b), (c), and (d) of Section 4616.7.

(2) For purposes of paragraph (1), a personal physician shall meet all of the following conditions:

(A) Be the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

(B) Be the employee's primary care physician and has previously directed the medical treatment of the employee, and

who retains the employee's medical records, including his or her medical history. "Personal physician" includes a medical group, if the medical group is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries.

(C) The physician agrees to be predesignated.

(3) If the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and the employer is notified pursuant to paragraph (1), all medical treatment, utilization review of medical treatment, access to medical treatment, and other medical treatment issues shall be governed by Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code. Disputes regarding the provision of medical treatment shall be resolved pursuant to Article 5.55 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(4) If the employee has health care coverage for nonoccupational injuries or illnesses on the date of injury in a group health insurance policy as described in Section 4616.7, all medical treatment, utilization review of medical treatment, access to medical treatment, and other medical treatment issues shall be governed by the applicable provisions of the Insurance Code.

(5) The insurer may require prior authorization of any nonemergency treatment or diagnostic service and may conduct reasonably necessary utilization review pursuant to Section 4610.

(6) An employee shall be entitled to all medically appropriate referrals by the personal physician to other physicians or medical providers within the nonoccupational health care plan. An employee shall be entitled to treatment by physicians or other medical providers outside of the nonoccupational health care plan pursuant to standards established in Article 5 (commencing with Section 1367) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(e) (1) When at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation administrative law judge, the employee submits to

examination by a physician, he or she shall be entitled to receive, in addition to all other benefits herein provided, all reasonable expenses of transportation, meals, and lodging incident to reporting for the examination, together with one day of temporary disability indemnity for each day of wages lost in submitting to the examination.

(2) Regardless of the date of injury, "reasonable expenses of transportation" includes mileage fees from the employee's home to the place of the examination and back at the rate of twenty-one cents ($0.21) a mile or the mileage rate adopted by the Director of Human Resources pursuant to Section 19820 of the Government Code, whichever is higher, plus any bridge tolls. The mileage and tolls shall be paid to the employee at the time he or she is given notification of the time and place of the examination.

(f) When at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation administrative law judge, an employee submits to examination by a physician and the employee does not proficiently speak or understand the English language, he or she shall be entitled to the services of a qualified interpreter in accordance with conditions and a fee schedule prescribed by the administrative director. These services shall be provided by the employer. For purposes of this section, "qualified interpreter" means a language interpreter certified, or deemed certified, pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code.

(g) If the injured employee cannot effectively communicate with his or her treating physician because he or she cannot proficiently speak or understand the English language, the injured employee is entitled to the services of a qualified interpreter during medical treatment appointments. To be a qualified interpreter for purposes of medical treatment appointments, an interpreter is not required to meet the requirements of subdivision (f), but shall meet any requirements established by rule by the administrative director that are substantially similar to the requirements set forth in Section 1367.04 of the Health and Safety Code. The administrative director shall adopt a fee schedule for qualified interpreter fees in accordance with this section. Upon request of the injured employee, the employer or insurance carrier shall pay for interpreter services.

An employer shall not be required to pay for the services of an interpreter who is not certified or is provisionally certified by the person conducting the medical treatment or examination unless either the employer consents in advance to the selection of the individual who provides the interpreting service or the injured worker requires interpreting service in a language other than the languages designated pursuant to Section 11435.40 of the Government Code.

(h) Home health care services shall be provided as medical treatment only if reasonably required to cure or relieve the injured employee from the effects of his or her injury and prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, and subject to Section 5307.1 or 5703.8. The employer shall not be liable for home health care services that are provided more than 14 days prior to the date of the employer's receipt of the physician's prescription.

SEC. 2. Section 4610.5 of the Labor Code is amended to read:

4610.5. (a) This section applies to the following disputes:

(1) Any dispute over a utilization review decision regarding treatment for an injury occurring on or after January 1, 2013.

(2) Any dispute over a utilization review decision if the decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

(b) A dispute described in subdivision (a) shall be resolved only in accordance with this section.

(c) For purposes of this section and Section 4610.6, the following definitions apply:

(1) "Disputed medical treatment" means medical treatment that has been modified, delayed, or denied by a utilization review decision.

(2) "Medically necessary" and "medical necessity" mean medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on the following standards, which shall be applied in the order listed, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee's medical condition:

(A) The guidelines adopted by the administrative director pursuant to Section 5307.27.

(B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(C) Nationally recognized professional standards.

(D) Expert opinion.

(E) Generally accepted standards of medical practice.

(F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

(3) "Utilization review decision" means a decision pursuant to Section 4610 to modify, delay, or deny, based in whole or in part on medical necessity to cure or relieve, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with, the provision of medical treatment services pursuant to Section 4600 or subdivision (c) of Section 5402.

(4) Unless otherwise indicated by context, "employer" means the employer, the insurer of an insured employer, a claims administrator, or a utilization review organization, or other entity acting on behalf of any of them.

(d) If a utilization review decision denies, modifies, or delays a treatment recommendation, the employee may request an independent medical review as provided by this section.

(e) A utilization review decision may be reviewed or appealed only by independent medical review pursuant to this section. Neither the employee nor the employer shall have any liability for medical treatment furnished without the authorization of the employer if the treatment is delayed, modified, or denied by a utilization review decision unless the utilization review decision is overturned by independent medical review in accordance with this section.

(f) As part of its notification to the employee regarding an initial utilization review decision that denies, modifies, or delays a treatment recommendation, the employer shall provide the employee with a form not to exceed two pages, prescribed by the administrative director, and an addressed envelope, which the employee may return to the administrative director or the administrative director's designee to initiate an independent medical review. The employer shall include on the form any information required by the administrative director to facilitate the

completion of the independent medical review. The form shall also include all of the following:

(1) Notice that the utilization review decision is final unless the employee requests independent medical review.

(2) A statement indicating the employee's consent to obtain any necessary medical records from the employer or insurer and from any medical provider the employee may have consulted on the matter, to be signed by the employee.

(3) Notice of the employee's right to provide information or documentation, either directly or through the employee's physician, regarding the following:

(A) The treating physician's recommendation indicating that the disputed medical treatment is medically necessary for the employee's medical condition.

(B) Medical information or justification that a disputed medical treatment, on an urgent care or emergency basis, was medically necessary for the employee's medical condition.

(C) Reasonable information supporting the employee's position that the disputed medical treatment is or was medically necessary for the employee's medical condition, including all information provided to the employee by the employer or by the treating physician, still in the employee's possession, concerning the employer's or the physician's decision regarding the disputed medical treatment, as well as any additional material that the employee believes is relevant.

(g) The independent medical review process may be terminated at any time upon the employer's written authorization of the disputed medical treatment.

(h) (1) The employee may submit a request for independent medical review to the division no later than 30 days after the service of the utilization review decision to the employee.

(2) If at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity, the time for the employee to submit a request for independent medical review to the administrative director or administrative director's designee is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved.

(3) If the employer fails to comply with subdivision (f) at the time of notification of its utilization review decision, the time

limitations for the employee to submit a request for independent medical review shall not begin to run until the employer provides the required notice to the employee.

(4) A provider of emergency medical treatment when the employee faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit a request for independent medical review on its own behalf. A request submitted by a provider pursuant to this paragraph shall be submitted to the administrative director or administrative director's designee within the time limitations applicable for an employee to submit a request for independent medical review.

(i) An employer shall not engage in any conduct that has the effect of delaying the independent review process. Engaging in that conduct or failure of the employer to promptly comply with this section is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five thousand dollars ($5,000) for each day that proper notification to the employee is delayed. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

(j) For purposes of this section, an employee may designate a parent, guardian, conservator, relative, or other designee of the employee as an agent to act on his or her behalf. A designation of an agent executed prior to the utilization review decision shall not be valid. The requesting physician may join with or otherwise assist the employee in seeking an independent medical review, and may advocate on behalf of the employee.

(k) The administrative director or his or her designee shall expeditiously review requests and immediately notify the employee and the employer in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefor. If there appears to be any medical necessity issue, the dispute shall be resolved pursuant to an independent medical review, except that, unless the employer agrees that the case is eligible for independent medical review, a request for independent medical review shall be deferred

if at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity.

(*l*) Upon notice from the administrative director that an independent review organization has been assigned, the employer shall provide to the independent medical review organization all of the following documents within 10 days of notice of assignment:

(1) A copy of all of the employee's medical records in the possession of the employer or under the control of the employer relevant to each of the following:

(A) The employee's current medical condition.

(B) The medical treatment being provided by the employer.

(C) The disputed medical treatment requested by the employee.

(2) A copy of all information provided to the employee by the employer concerning employer and provider decisions regarding the disputed treatment.

(3) A copy of any materials the employee or the employee's provider submitted to the employer in support of the employee's request for the disputed treatment.

(4) A copy of any other relevant documents or information used by the employer or its utilization review organization in determining whether the disputed treatment should have been provided, and any statements by the employer or its utilization review organization explaining the reasons for the decision to deny, modify, or delay the recommended treatment on the basis of medical necessity. The employer shall concurrently provide a copy of the documents required by this paragraph to the employee and the requesting physician, except that documents previously provided to the employee or physician need not be provided again if a list of those documents is provided.

(m) Any newly developed or discovered relevant medical records in the possession of the employer after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The employer shall concurrently provide a copy of medical records required by this subdivision to the employee or the employee's treating physician, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of medical records shall be maintained pursuant to applicable state and federal laws.

(n) If there is an imminent and serious threat to the health of the employee, as specified in subdivision (c) of Section 1374.33 of the Health and Safety Code, all necessary information and documents required by subdivision (*l*) shall be delivered to the independent medical review organization within 24 hours of approval of the request for review.

(o) The employer shall promptly issue a notification to the employee, after submitting all of the required material to the independent medical review organization, that lists documents submitted and includes copies of material not previously provided to the employee or the employee's designee.

SEC. 3. Section 4903 of the Labor Code is amended to read:

4903. The appeals board may determine, and allow as liens against any sum to be paid as compensation, any amount determined as hereinafter set forth in subdivisions (a) through (i). If more than one lien is allowed, the appeals board may determine the priorities, if any, between the liens allowed. The liens that may be allowed hereunder are as follows:

(a) A reasonable attorney's fee for legal services pertaining to any claim for compensation either before the appeals board or before any of the appellate courts, and the reasonable disbursements in connection therewith. No fee for legal services shall be awarded to any representative who is not an attorney, except with respect to those claims for compensation for which an application, pursuant to Section 5501, has been filed with the appeals board on or before December 31, 1991, or for which a disclosure form, pursuant to Section 4906, has been sent to the employer, or insurer or third-party administrator, if either is known, on or before December 31, 1991.

(b) The reasonable expense incurred by or on behalf of the injured employee, as provided by Article 2 (commencing with Section 4600), and to the extent the employee is entitled to reimbursement under Section 4621, medical-legal expenses as provided by Article 2.5 (commencing with Section 4620) of Chapter 2 of Part 2, except those disputes subject to independent medical review or independent bill review.

(c) The reasonable value of the living expenses of an injured employee or of his or her dependents, subsequent to the injury.

(d) The reasonable burial expenses of the deceased employee, not to exceed the amount provided for by Section 4701.

(e) The reasonable living expenses of the spouse or minor children of the injured employee, or both, subsequent to the date of the injury, where the employee has deserted or is neglecting his or her family. These expenses shall be allowed in the proportion that the appeals board deems proper, under application of the spouse, guardian of the minor children, or the assignee, pursuant to subdivision (a) of Section 11477 of the Welfare and Institutions Code, of the spouse, a former spouse, or minor children. A collection received as a result of a lien against a workers' compensation award imposed pursuant to this subdivision for payment of child support ordered by a court shall be credited as provided in Section 695.221 of the Code of Civil Procedure.

(f) The amount of unemployment compensation disability benefits that have been paid under or pursuant to the Unemployment Insurance Code in those cases where, pending a determination under this division there was uncertainty whether the benefits were payable under the Unemployment Insurance Code or payable hereunder; provided, however, that any lien under this subdivision shall be allowed and paid as provided in Section 4904.

(g) The amount of unemployment compensation benefits and extended duration benefits paid to the injured employee for the same day or days for which he or she receives, or is entitled to receive, temporary total disability indemnity payments under this division; provided, however, that any lien under this subdivision shall be allowed and paid as provided in Section 4904.

(h) The amount of family temporary disability insurance benefits that have been paid to the injured employee pursuant to the Unemployment Insurance Code for the same day or days for which that employee receives, or is entitled to receive, temporary total disability indemnity payments under this division, provided, however, that any lien under this subdivision shall be allowed and paid as provided in Section 4904.

(i) The amount of indemnification granted by the California Victims of Crime Program pursuant to Article 1 (commencing with Section 13959) of Chapter 5 of Part 4 of Division 3 of Title 2 of the Government Code.

SEC. 4. Section 4903.07 of the Labor Code is amended to read:

4903.07. (a) A lien claimant shall be entitled to an order or award for reimbursement from the employer of a lien filing fee or

lien activation fee, together with interest at the rate allowed on civil judgments, only if all of the following conditions are satisfied:

(1) Not less than 30 days before filing the lien for which the filing fee was paid or filing the declaration of readiness for which the lien activation fee was paid, the lien claimant has made written demand for settlement of the lien claim for a clearly stated sum which shall be inclusive of all claims of debt, interest, penalty, or other claims potentially recoverable on the lien.

(2) The defendant fails to accept the settlement demand in writing within 20 days of receipt of the demand for settlement, or within any additional time as may be provide by the written demand.

(3) After submission of the lien dispute to the appeals board or an arbitrator, a final award is made in favor of the lien claimant of a specified sum that is equal to or greater than the amount of the settlement demand. The amount of the interest and filing fee or lien activation fee shall not be considered in determining whether the award is equal to or greater than the demand.

(b) This section shall not preclude an order or award of reimbursement of the filing fee or activation fee pursuant to the express terms of an agreed disposition of a lien dispute.

SEC. 5. Section 4903.8 of the Labor Code is amended to read:

4903.8. (a) (1) Any order or award for payment of a lien filed pursuant to subdivision (b) of Section 4903 shall be made for payment only to the person who was entitled to payment for the expenses as provided in subdivision (b) of Section 4903 at the time the expenses were incurred, and not to an assignee unless the person has ceased doing business in the capacity held at the time the expenses were incurred and has assigned all right, title, and interest in the remaining accounts receivable to the assignee.

(2) Paragraph (1) does not apply to an assignment that was completed prior to January 1, 2013, or that was required by a contract that became enforceable and irrevocable prior to January 1, 2013. This paragraph is declarative of existing law.

(b) If there has been an assignment of a lien, either as an assignment of all right, title, and interest in the accounts receivable or as an assignment for collection, a true and correct copy of the assignment shall be filed and served.

(1) If the lien is filed on or after January 1, 2013, and the assignment occurs before the filing of the lien, the copy of the assignment shall be served at the time the lien is filed.

(2) If the lien is filed on or after January 1, 2013, and the assignment occurs after the filing of the lien, the copy of the assignment shall be served within 20 days of the date of the assignment.

(3) If the lien is filed before January 1, 2013, the copy of the assignment shall be served by January 1, 2014, or with the filing of a declaration of readiness or at the time of a lien hearing, whichever is earliest.

(c) If there has been more than one assignment of the same receivable or bill, the appeals board may set the matter for hearing on whether the multiple assignments constitute bad-faith actions or tactics that are frivolous, harassing, or intended to cause unnecessary delay or expense. If so found by the appeals board, appropriate sanctions, including costs and attorney's fees, may be awarded against the assignor, assignee, and their respective attorneys.

(d) At the time of filing of a lien on or after January 1, 2013, or in the case of a lien filed before January 1, 2013, at the earliest of the filing of a declaration of readiness, a lien hearing, or January 1, 2014, supporting documentation shall be filed including one or more declarations under penalty of perjury by a natural person or persons competent to testify to the facts stated, declaring both of the following:

(1) The services or products described in the bill for services or products were actually provided to the injured employee.

(2) The billing statement attached to the lien truly and accurately describes the services or products that were provided to the injured employee.

(e) A lien submitted for filing on or after January 1, 2013, for expenses provided in subdivision (b) of Section 4903, that does not comply with the requirements of this section shall be deemed to be invalid, whether or not accepted for filing by the appeals board, and shall not operate to preserve or extend any time limit for filing of the lien.

(f) This section shall take effect without regulatory action. The appeals board and the administrative director may promulgate regulations and forms for the implementation of this section.

SEC. 6. Section 5410 of the Labor Code is amended to read:

5410. Nothing in this chapter shall bar the right of any injured worker to institute proceedings for the collection of compensation within five years after the date of the injury upon the ground that the original injury has caused new and further disability. The jurisdiction of the appeals board in these cases shall be a continuing jurisdiction within this period. This section does not extend the limitation provided in Section 5407.

Approved _____, 2014

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Governor